

Patient Registration - Please print clearly

Name [Mr / Mrs / Dr / Ms / Miss]: _____

Date of birth: _____ Social Security # _____ - _____ - _____

Address: _____
_____ - _____ [zip]

Cell Phone _____ Home # _____ Work # _____

Personal Primary Physician: _____

Physician who [if] referred you : _____

Date last seen by physician or / PA /Nurse: _____

Emergency contact information: _____

Insurance Information [bring insurance card(s) to visit, or copy of both sides]

Primary Insurance Plan Name (include all prefix and suffix letters)

ID # _____ Group number _____ Other info _____

Primary policy holder : complete the following if different than above patient (eg, patient is child insured via parents so parents complete below ; or patient is spouse or companion who does not have their own employment insurance so we need the insured spouses / companions demographic information)

Name: _____

Date of birth: _____ Male / Female _____

Occupation: _____ Work phone _____

Business Address: _____

Home Address: _____ Home/Cell# _____

Secondary Insurance Plan Name (prefix and suffix letters)

ID # _____ Group number _____

Secondary policy : complete the following if different than patient (eg, patient is child insured via two separate parent plans ; patient is spouse /companion who does have their own employment insurance but is also insured via other)

Name: _____

Date of birth: _____ Male / Female _____

Occupation: _____ Work phone: _____

Business Address: _____

Home Address: _____ Home / Cell #s _____

Consents and Agreements - Please read - print name and sign

- All office visit fees must be paid at the time of visit (if your insurance does not cover office visits, or if you have no insurance) including co-pays, and deductibles. As a courtesy, we will submit x-rays, surgeries, procedures to one insurance carrier if we are not a member of that panel or a participant. *If these submissions are not processed and paid within 60 days from the date of service, then all fees will become your responsibility.*
- Patients are responsible for all insurance plan referrals requirements, HMO requirements, out network processes and other restrictions that may apply to their policies.

_____ I give permission for evaluation and treatment of my condition. I will inform the office of any treatments or procedures that I do not desire, at any time, or while options of care being discussed

_____ I acknowledge that I am personally financially responsible for those charges not totally covered by insurance. Any invoices not paid when due will be charged a service charge (minimum five dollars) and 1&½ % interest per month (18% annually) and any direct costs (eg . Postage, certified fees)

_____ I am aware that charges are made for missed appointments or those without twenty four hours notice of cancellation. An answering machine is available 24 /7 .

_____ For past due accounts, managed via the magisterial district justice courts, I am aware that the customer is also liable for all collection costs, including court costs, office processing costs, and attorney fees.

Patient Signature & Printed name [initial above lines]

Signature of Parent (if minor child / child insured via parent) or POA or Spouse if patient unable to sign

Please indicate if you are paying co-pay or non covered service by _____ **Cash** _____ **Check**

Special Note for out of town parents. If you are giving permission for your child to use your insurance, and if you want to be directly billed and responsible for co-payments, deductible charges and any other costs, please additionally sign here and provide both parent names, addresses, phone numbers, and any other information

Dr Larry Assalita - Podiatric Patient History

Please fill out separate sports medicine history form if appropriate

Please note: Do not hesitate to provide any length of a summary or narrative of your entire history as related to your feet. You live with the problem 24 hours a day, and you may have insight, or information, that may make treatment more successful. There are no right or wrong answers - just answer with your first impression.

Indicate Right Foot, Left Foot, or Both here → _____ or indicate R / L / B in each question if varies

Primary Purpose of appointment :

Secondary Concerns:

What do you think the problem is ?

How long have you noticed the problem (s) ?:

Has it changed ?

Previous physician care ?

What have you tried ?

What makes it better / What makes it worse ?

How did you select / hear about this office ?

Is there anything you want us to know about you, your circumstances, family , work or other history ?

Activity and standing at work:

Activity and standing at home:

Height: _____ **Weight** _____ [has it increased or decreased] _____


Shoe size / brands / styles (s)

Has size changed _____ When don't you wear shoes ? _____

Are there dress code or other shoe wear requirements:

Alcohol : (how many years and amount / day / wk and type) _____

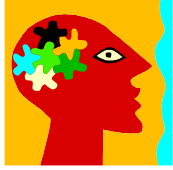
Smoking use: per day / how many years & what do you smoke : _____

If you no longer smoke, when did you quit ?  _____

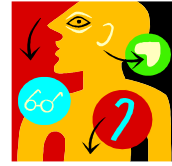
Recreational or other substance use _____

List **ALLERGIES** and type of reaction you have to any medication, materials or products :

Don't forget to include aspirin, iodine, local anesthetic, latex, , adhesives, soaps, fabrics, and non prescription products



Medical History



List medications: include vitamins, recreational drugs, birth control, smoking cessation, diet pills, supplements, eye drops. List the name [generic or brand]; purpose; strength; times a day; when started; and who provides the Rx for you. If you have a legible list to photocopy for your chart, you do not need to separately complete this section. Use the back of this form if necessary.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

List FOOT surgery or foot care: include physician; facility; date; original problems; satisfaction of the results, any complications or problems. If you are coming here as an alternative opinion, or other care related to this, possibly bring records.

- 1.
- 2.
- 3.

List other surgery: Leg, hip, knee, and back are more important in details (particularly if you are having foot pain, numbness).

Identify anything where complications or problems or less than desirable outcomes occurred

- | | |
|----|----|
| 1. | 2. |
| 3. | 4. |
| 5. | 6. |

Do you currently have, or did you in the past have, any symptoms, medical or other care for any of the following?

And in the space below or on the reverse list any important details not already referenced in the rest of this registration. When possible, if you have any current general medical care, have your primary physician's office fax us your most recent office visit notes.

Musculoskeletal: back pain / arthritis / neck pain / ulcers / sciatica / joint implants / sprains / fractures

Skin: warts / ingrown nails / heat or cold sensitivity / athlete's foot / cancer / tattoos / piercing

Cardiovascular: anemia / abnormal bleeding / heart problems / CVA / murmur / pacemaker / bypass legs

Urinary & Reproductive issues: prostate / hysterectomy / HIV / infections / ED / VD / kidney / gout

Central organs: stomach ulcers, / bowel, / diabetes / liver problems / hepatitis / appendix / gout /

Head / Neck: dental surgery / cataracts / contacts / glaucoma / hearing loss / hearing aid / asthma / thyroid

Neurological: seizure / neuropathy / ADHD / depression / psychiatric / memory issues / stroke

Miscellaneous

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if so chose) ;Or may view it and print it at www.DrAssalita.com and understood the notice.

PLEASE COMPLETE THE FOLLOWING (those on web , print out this and other forms and bring to your office appointment)




PRINTED NAME :

Printed name and relationship of Parent or authorized Representative :

Signature: _____

DATE: _____



Note: please indicate who you authorize hear,  see, , talk  Or otherwise communicate about you and release your records information to at this time ; and their status to you. You do not need to indicate anyone. However, please note, if for example, you have a spouse or companion, and they want to inquire on your behalf about anything (including your bills etc), if you do not list them, we cannot communicate with them until we would then get your permission. You may want to consider also listing a spouse , if you are here with your child. Or adult children, if you are elderly / live alone.

NAME: _____

STATUS: _____

NAME: _____

STATUS: _____


NAME: _____

STATUS: _____

NAME: _____

STATUS: _____



NOTE :  We can communicate about medical issues directly to other physicians , but it is also nice to list them here, if you want copies of your consultation or other notes to go to them . Please add addition information as needed. Thanks.